



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

February 20, 2008

Jason Fletcher, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 N Cloverdale Rd
Boise, ID 83713

License #: RC-555

Dear Mr. Fletcher:

On December 13, 2007, a complaint investigation, state licensure survey was conducted at Ashley Manor - Cloverdale, Ashley Manor Llc. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, LMSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Polly Watt-Geier, LMSW". The signature is written in a cursive, flowing style.

POLLY WATT-GEIER, LMSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

December 27, 2007

Jason Fletcher, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 N Cloverdale Rd
Boise, ID 83713

Dear Mr. Fletcher:

On December 13, 2007, a complaint investigation, state licensure survey was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by January 13, 2008.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Simpson", written over a horizontal line.

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R555	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2007
NAME OF PROVIDER OR SUPPLIER ASHLEY MANOR - CLOVERDALE, ASHLEY M.			STREET ADDRESS, CITY, STATE, ZIP CODE 3749 N CLOVERDALE RD BOISE, ID 83713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>Initial Comments</p> <p>The residential care/assisted living facility was found to be in substantial compliance with the Rules for Residential Care or Assisted Living Facilities in Idaho. No core issue deficiencies were cited during the standard survey and complaint investigation conducted at your facility. The surveyors conducting the survey were:</p> <p>Polly Watt-Geier, MSW Team Coordinator Health Facility Surveyor</p> <p>Diane Schafer, RD, CDE Health Facility Surveyor</p> <p>Donna Henscheid, LSW Health Facility Surveyor</p>	R 000			

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

HHH011

If continuation sheet 1 of 1



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December 28, 2007

Jason Fletcher, Administrator
Ashley Manor - Cloverdale, Ashley Manor LLC
3749 N Cloverdale Rd
Boise, ID 83713

Dear Mr. Fletcher:

On December 13, 2007, a complaint investigation survey was conducted at Ashley Manor - Cloverdale, Ashley Manor LLC. The survey was conducted by Diane Schafer, RD, Donna Henscheid, LSW and Polly Watt-Geier, MSW. This report outlines the findings of our investigation.

Complaint # ID00003229

Allegation #1: The facility caregivers were not frequently checking on a resident.

Findings: Based on record review and interview, it could not be determined the resident had not been checked on frequently.

Review of the resident's closed record showed that there was one incident of the resident being found lying on the floor partially under the bed on September 22, 2007 at 8:30 AM. It was further documented the bed was lowered to the floor and a foam pad was placed next to the bed. Interviews with caregivers and the owner on December 12, 2007 between 4:02 PM and 4:42 PM revealed the resident was checked on frequently throughout the day and night. The hospice nurse was interviewed on December 13, 2007 at 11:39 AM and she stated the bed was lowered to the floor after the resident was found lying under the bed.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #2: The facility did not provide adequate supervision.

Findings: Based on record review and interview, it was determined the facility did not provide adequate supervision to include the consistent use of a tab alarm.

The resident's closed record contained an NSA dated 7/07 which documented the resident required the use of the tab alarm in bed and the wheelchair to prevent falls. There was one documented occasion where the tab alarm was found to be unsecured on the resident. On December 12, 2007 at 4:42 PM, the former house manager stated the tab alarm clip was not working properly and would release at times. On December 13, 2007 at 7:40 AM, a family member stated the tab alarm was not used. On December 13, 2007 at 11:39 AM, the hospice nurse stated the tab alarm was not used consistently.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.305.01 for the facility RN not assessing the resident's response to the use of a tab alarm and 16.03.22.305.08 for the facility RN not providing staff education on the consistent use of a tab alarm. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not follow the resident's care plan.

Findings: Based on record review and interview, it could not be determined the facility did not follow the resident's care plan.

The resident's closed record contained documented evidence that after September 22, 2007, the resident's bed was lowered to the floor to prevent falls. The caregivers and owner were interviewed on December 12, 2007 between 4:02 PM and 4:42 PM and they confirmed the bed was lowered after September 22, 2007. The hospice nurse was interviewed on December 13, 2007 at 11:39 AM when she stated the bed was lowered toward the end of the resident's stay at the facility.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4: Facility staff did not have the special training required to work with Alzheimer/Dementia residents.

Findings: Based on record review and staff interview, it was determined that the facility did provide training for staff to work with residents with Alzheimer/Dementia.

On December 12, 2007 at 2:30 PM, a review of 4 personnel records confirmed that the staff received training during orientation that included working with residents who have Alzheimer/Dementia. On December 12, 2007 at 1:30 PM, the house manager stated that all employees were required to have training on special needs of residents during orientation.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #5: The facility did not provide adequate care.

Findings: Based on record review and interview, it could not be determined that the staff did not provide adequate care for the resident.

Closed record review showed the resident's NSA included frequent staff assistance with toileting throughout the day and night due to the resident's incontinence. The resident's record did not document that the resident was left for long time periods however the resident was found after incontinent episodes on occasions. The interviews with the caregivers and owner on December 12, 2007 between 4:02 PM and 4:42 PM, revealed that the resident was not left for long periods of time while incontinent. On December 13, 2007 at 11:39 AM, the hospice nurse reported she had found the resident in need of changing on occasion but did not know the length of time he was in that condition.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #6: The facility called 911 before notifying the resident's hospice nurse.

Findings: Based on record review and interview, it was determined the facility acted appropriately by calling 911.

The resident's closed record contained documentation that a caregiver observed the resident having what appeared to be seizure activity on August 21, 2007 at 4:00 PM. The caregiver immediately called 911 and the resident was transferred to the hospital. On December 13, 2007 at 7:40 AM, a family member stated that the resident had been transported to the hospital by EMS.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by notifying emergency services when the resident experienced a life threatening situation.

Allegation #7: The facility did not monitor a resident's nutritional status.

Findings: Based on record review and interview, it was determined the facility did not document and monitor accurately the resident's food and supplement consumption.

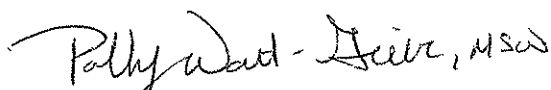
A record review of the resident's closed record, hospice records, and physician notes indicate that the resident had chewing and swallowing difficulty for which the resident required a puree diet with supplementation. It was not documented that the resident received any nutritional supplement on the MAR for August and September 2007. The physician progress notes from May to September 2007, documented that the resident was not eating well continued to experience weight loss. On December 12, 2007 between 4:02 PM and 4:42 PM, the caregivers and owner stated the

resident would vary in his food consumption from 0-100% of his meals and that the resident was taking his supplement.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.08.b for not documenting the resident's nutritional supplement use on the MAR. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,



POLLY WATT-GEIER, MSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

PWG/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Polly Watt-Geier, MSW, Health Facility Surveyor



Facility Name <i>Ashley Manor Cloverdale</i>	Physical Address <i>3749 N Cloverdale</i>	Phone Number <i>377-4929</i>
Administrator <i>Jason Fletcher</i>	City <i>Boise</i>	ZIP Code <i>83713</i>
Survey Team Leader <i>Dolly Watt-Gaier</i>	Survey Type <i>Standard Survey/Complaint</i>	Survey Date <i>12/13/07</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	305.01	The facility RN did not conduct a nursing assessment of Resident #4's response to Ensure nor Resident #6's use of Ensure or Tag alarm.		2/25/08
2	305.02	The facility RN did not assess or obtain an MD order for Residents #4 and #6's modified diet (Soft vs Purées foods)		2/1/08 DS
3	305.08	The facility RN did not provide staff education on the consistent use of Resident #6's tag alarm.		2/1/08 DS
4	320.02.b	The facility did not update Resident #3's NSA to accurately reflect his level of ADL needs.		1/25/08 DS
5	320.03	Resident #3's NSA was not signed by administrator or family and was pre-dated by the facility RN		1/25/08 DS
6	350.07	The administrator or designers did not notify the licensing and certification agency of reportable incidents.		1/25/08 DS

Response Required Date <i>1/13/08</i>	Signature of Facility Representative 	Date Signed <i>12/13/07</i>
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IDAHO DEPARTMENT OF
HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues
Punch List

Facility Name <i>Ashley Manor Cloverdale</i>	Physical Address <i>3749 N Cloverdale</i>	Phone Number <i>377-4929</i>
Administrator <i>Jason Fletcher</i>	City <i>Boise</i>	ZIP Code <i>83713</i>
Survey Team Leader <i>Polly WAT - Galar</i>	Survey Type <i>Standard Survey / Complaint</i>	Survey Date <i>12/13/07</i>

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
7	450.	The facility did not meet the standards of the Idaho Food Code, IDAPA 16.02.19. See Food Establishment Inspection Report 12/13/07.		2/1/08 DS
8	550.03.biii	The facility did not provide Resident #1 and a random resident with the right to be communicated with in a language they understand.	COS 12/13/07 pub	
9	711.04	The facility did not monitor or document Resident #6's refusal of meals and nutritional supplements.		1/25/08 DS
10	711.08.b	The facility did not document on the MAR Resident #4 and 6's receipt of nutritional supplements.		1/25/08 DS
11	310.03	The facility did not track controlled substances in accordance with the Board of Pharmacy rules i.e. inconsistent methods of documentation, no documentation for medication given and number of pills did not match pills recorded.		1/26/08 DS

Response Required Date <i>1/13/08</i>	Signature of Facility Representative 	Date Signed <i>12/13/07</i>
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